HMIG (20) 07
Minutes

Minutes of a Meeting of the
COVID-19 - Health Ministerial Implementation Group
held via Zoom on

TUESDAY 7th April 2020
At 1200 PM

P R E S E N T

The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

The Rt Hon Robert Jenrick, MP
Secretary of State for Housing, Communities and Local Government

The Rt Hon Dr Thérèse Coffey MP
Secretary of State for Work and Pensions

The Rt Hon Stephen Barclay MP
Chief Secretary to the Treasury

The Rt Hon Mark Drakeford AM
First Minister of Wales

The Rt Hon Simon Hart MP
Secretary of State for Wales

The Rt Hon Christopher Pincher MP
Minister of State for Housing and Planning

Helen Whately MP
Minister of State (Minister for Care)

Vicky Ford MP
Parliamentary Under Secretary of State for Children and Families

Edward Argar MP
Minister of State (Minister for Health)

Caroline Dinenage MP

The Rt Hon George Eustice MP
Secretary of State for Environment, Food and Rural Affairs

The Rt Hon Michael Gove MP
Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office

The Rt Hon Penny Mordaunt MP
Paymaster General

The Rt Hon Michael Ellis QC MP Solicitor General

The Rt Hon Alister Jack MP
Secretary of State for Scotland

Joe FitzPatrick MSP
Minister for Public Health, Sport and Wellbeing

Robin Swann MLA
Minister of Health

James Heappey MP
Parliamentary Under Secretary of State (Minister for the Armed Forces)

Baroness Williams of Trafford
Lords Minister at the Home Office

Robin Walker MP

Minister of State (Minister for Digital and Culture)

James Dudderidge MP
Parliamentary Under Secretary of State (Minister for Africa)

Minister of State (Northern Ireland Office)

Amanda Solloway
Parliamentary Under Secretary of State (Minister for Science, Research and Innovation)

ALSO PRESENT

Sir Simon Stevens
Chief Executive, NHS

Ian Dodge
National Director for Strategy and Innovation, NHS

Professor Jonathan Van Tam
Deputy Chief Medical Officer for England

Professor John Newton
Director of Health Improvement, Public Health England

Dr Katherine Newell
Scientific Advisory Group for Emergencies

Sir John Manzoni
Chief Executive of the Civil Service and Permanent Secretary, Cabinet Office

Simon Ridley
Director General C-19 Healthcare Ministerial Implementation Group, Cabinet Office

Alison Pritchard
Interim Director General, Government Digital Service

Rosemary Pratt
Director C-19 Healthcare Ministerial Implementation Group, Cabinet Office

Clara Swinson
Director General for Global and Public Health, Department of Health and Social Care

Rosamond Roughton
Director of Adult Social Care, Department of Health and Social Care

Antonia Williams

Director of Mental Health, Dementia and Disabilities, Department of Health and Social Care

Chris Townsend
Director for Shielding, Ministry of Housing, Communities and Local Government

Fiona Deans
Chief Operating Officer, Government Digital Service

Tom Irving
Scientific Pandemic Influenza Group on Modelling

Richard Foggo
Director of Population Health, Scottish Government

Kate Thomas
Deputy Director - Communications, Department of Health and Social Care

Name Redacted
COVID-19 Project Team, Welsh Government

Name Redacted
Government Legal Department

Name Redacted
Devolved Administration Liaison - C-19 Secretariat

Name Redacted
Civil Contingencies Secretariat

Name Redacted
Private Secretary to the Special Advisers of the Chancellor of the Duchy of Lancaster

Damon Poole
Special Adviser to the Prime Minister

Secretariat

Name Redacted

Introduction

THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said that the Group would review the current situation in Adult Social Care, which was a mission-critical element of keeping capacity in the NHS. The Group would also cover delivery of the shielding programme for clinically vulnerable people as well as an update on the health impacts of social distancing. Personal Protective Equipment (PPE) would be discussed in further detail at the next Healthcare Ministerial Implementation Group.

Adult Social Care System Readiness

THE MINISTER OF STATE FOR CARE said that there had been a lot of cross-government work to support Adult Social Care although the system was under pressure due to COVID-19. 9.7% of care homes in England had reported outbreaks of COVID-19, although this figure was higher in London. Data was being collected from the NHS England Capacity Tracker to give a picture of the system and covered over 70% of care homes at present. From the data available, occupancy was at 90% meaning there was some available care home capacity. RAG ratings across admission status, workforce and PPE were being collected from care homes and could potentially be shared with Local Authorities and MHCLG to compile into a LRF dashboard. An app was being developed by the Care Quality Commission (CQC) to allow domiciliary providers to input data and to allow providers to flag issues to receive further support.

Continuing, THE MINISTER OF STATE FOR CARE said that discharges from hospital into the community to increase NHS capacity had been hugely successful. Non-COVID bed occupancy had reduced by nearly 40,000 patients since 2nd March, against the target of 30,000. Clear guidance on discharge processes and care home acceptances had been published. DHSC were aware of some concerns in the sector and guidance on infection control was under review. Further work was ongoing to model future discharge volumes and likely acuity of patients to ensure Adult Social Care capacity was sufficient in the coming weeks and months.

Continuing, THE MINISTER OF STATE FOR CARE said that ensuring parity in the approach between the NHS and social care for PPE and testing was important. PPE was being delivered to social care providers from national stocks and they could contact the National Supply Disruption Response hotline in emergencies. A new channel through Clipper Logistics was also being established to deliver PPE to social care providers. Social care workers were also to be tested alongside NHS staff where capacity permits in order to reduce staff absences. There has also been a growth in interest around jobs in the care sector. Online training capacity has been scaled up and the DBS process shortened to create a pool of potential workers that providers can tap into.

Continuing, THE MINISTER OF STATE FOR CARE said that ensuring the financial viability of providers was vital. The Local Government Association (LGA) and Association for Directors of Adult Social Services would be publishing guidance for Local Authorities on how best to support providers. DHSC were also continuing to monitor provider financial health through the CQC's existing oversight scheme. The Coronavirus Act and associated Care Act easements allowed Local Authorities to prioritise care to meet the most urgent and acute needs. Work was also underway to ensure that care homes are supported to manage end of life care for residents where that is the choice of the individual and the family.

In discussion, the following points were made:

- work on metrics for Adult Social Care had moved forward at pace. By the end of the current week, there would be a Local Resilience Forum (LRF) dashboard covering a range of measures across Local Government such as health and social care, business continuity and death management.
- the LGA has requested a focus on encouraging recent leavers from social care professions to return to this work in the current crisis, which is being picked up between the THE SECRETARY OF STATE FOR HOUSING, COMMUNITIES AND LOCAL GOVERNMENT and THE MINISTER OF STATE FOR CARE;
- ensuring data reporting compliance from all care home providers was a priority. There were some concerns that data reporting by providers would be used by Local Authorities to penalise them, but this should not be a blocker to reporting;
- the current rate of deaths in care homes was being tracked against the normal rate, to provide a sense of the scale of excess deaths due to COVID-19. It would be important to develop a sensitive narrative about deaths in care homes;
- work on discharges was welcome and the number of patients with a hospital stay of over 21 days had halved;
- financial resilience for the care sector would be vital in keeping enough capacity in the NHS to deal with any potential uplift in admissions. There were four care home beds for every hospital bed and so a relatively small percentage reduction (around 7%) in care home availability could lead to all available capacity in the NHS being filled with patients unable to be discharged.
- it was vital to ensure that funding reaches care home operators in order to keep this capacity. THE MINISTRY OF HOUSING, COMMUNITIES AND LOCAL GOVERNMENT was working closely with HER MAJESTY'S TREASURY to ensure cash flow issues in some lower-tier authorities did not disrupt provision of social care;

- a UK-wide approach would need to be taken to support social care providers with funding and PPE, not least because some providers operate across the UK.

Summing up, THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said that the Adult Social Care sector, and in particular care homes, were hugely important in looking after those most vulnerable during this crisis and should be supported to continue to do so.

The Group:

- took note.

Delivery of Shielding Support

THE SECRETARY OF STATE FOR HOUSING, COMMUNITIES AND LOCAL GOVERNMENT said that so far in the shielding programme, the 900,000 people on the initial clinically vulnerable list had been written to twice, 70,000 food boxes had been delivered and the call centre had made almost 250,000 outbound calls. The call centre would be aiming to call up to four times each clinically vulnerable individual who had not responded to the letter. The NHS had now identified a further 417,000 people with medical conditions that made them clinically vulnerable, which brought the full list for England to 1.285m people. Through cleansing of the list, 126,000 people had been identified as no longer needing to 'shield', but these should be kept on the list at present to avoid conflicting communications.

Continuing, THE SECRETARY OF STATE FOR HOUSING, COMMUNITIES AND LOCAL GOVERNMENT said that two different courses of action were proposed for the 579,000 individuals who had registered but were not on the central NHS list. The action would depend on whether they registered before or after the website wording had been clarified:

- The data of the 166,000 people who had registered before ('cohort 1') would be shared with their GP and they would be communicated with to direct them to their Local Authority if in need of immediate support. The data of the 85,000 of cohort 1 who had requested support with food would also be shared with supermarkets to allow for prioritised online deliveries.
- The 413,000 people who had registered after the wording change ('cohort 2'), would not be offered any additional support. They would instead be contacted quickly and advised they would only be eligible for support if identified by the NHS as clinically vulnerable, and that they should contact their GP if they considered themselves to be so. They would also be directed to their Local Authority if in need of immediate support.

Continuing, THE SECRETARY OF STATE FOR HOUSING, COMMUNITIES AND LOCAL GOVERNMENT said that social contact was an important part of meeting the broader needs of the shielded cohort. The proposed approach was for Local Authorities to populate the GoodSAM app with volunteering opportunities for 'check in and chat' volunteers, so that every person who might be socially isolated due to shielding would receive at least a weekly call. This approach would not be too prescriptive, so that local areas to make the best use of volunteers. Local Authorities would also be receiving data on those people who had registered as having basic care needs.

In discussion, the following points were made:

- there was a variety of GoodSAM app volunteers, family and friends and community pharmacies services providing medicine delivery to those shielding who had requested support;
- NHS Digital had sent letters to those individuals who had been added to the shielding list. The new additions to the shielding list (based on their clinical condition) needed to be compared to the list of people who had self-registered without an NHS letter. GPs were now adding their patients to the list if they matched a strict set of clinical criteria that would require them to shield. NHS Digital was working through the technical challenge with getting the information from GPs added back onto the central shielding list, including exploring manual workarounds;
- the Healthcare Ministerial Implementation Group should review the decision on the 126,000 who might no longer need to shield after the GP review of patients has concluded. Shielding would have a significant impact on a person's life and wellbeing and so should only be done if clinically necessary;
- clear communications would need to be provided to non-English speakers;
- data on the number of individuals under eighteen among the clinically vulnerable should be provided;
- the call centre activity was progressing. There was a manual link from the central database (of website and Interactive Voice Response (IVR) activity) to the call centre. GDS were aware of the additional requirements for a dynamic linkage for this data. All of the patients in the original list would have had at least one contact by the previous Sunday, and the additional patients by the following Sunday. The call centre capacity could potentially expand to take on follow up calls;
- it was important to provide an 'opt-out' route for people who no longer required the standardised food parcels and could instead receive food through prioritised online delivery from supermarkets, or from family and friends. Supermarkets had scope to take on details of additional people needing food and essential supplies so that they could prioritise online delivery slots;
- those who had died had been taken off the clinically vulnerable list.

Summing up, THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said that the proposals from THE SECRETARY OF STATE FOR HOUSING, COMMUNITIES AND LOCAL GOVERNMENT were agreed. This included that those who self-registered after the website wording change ('cohort 2') should be communicated with in the next 48 hours to confirm to them that they needed an NHS letter to be eligible for shielding support and direct them to their Local Authority if they were in immediate need of support. The MINISTRY OF HOUSING, COMMUNITIES AND LOCAL GOVERNMENT should work with the DEPARTMENT FOR HEALTH AND SOCIAL CARE and GOVERNMENT DIGITAL SERVICE to agree and deliver this communication. In addition:

- GPs should check the list of 166,000 people who had self-registered before the website wording clarification, once they received their details;
- A future Healthcare Ministerial Implementation Group would consider how best to link the 431,000 people who self-registered after the website wording clarification ('cohort 2') with the wider support network, given GPs were not currently being asked to review these individuals;
- A future Healthcare Ministerial Implementation Group would also consider an action plan for the 126,000 who might no longer need to shield.

The Group:

- took note.

Health Impacts of Social Distancing

THE DEPUTY CHIEF MEDICAL OFFICER said that it was too early to make a decision on adjustments to social distancing measures. There would not be reliable evidence until mid April, so this consideration of health impacts had used the best evidence available to date. The rate of increase in hospital admissions and admissions to Intensive Care Units (ICUs) had slowed. The decision looked more likely about whether - and if so which - measures could be relaxed, but could only be taken with sufficient evidence to do so.

Continuing, THE DEPUTY CHIEF MEDICAL OFFICER said that there were two key components required for modelling that were currently missing. These were:

- serology data to show the proportion of the population who had been infected by the first wave of the pandemic versus the proportion that remain susceptible;
- more clarity on the role of children in transmission which would affect decisions on reopening schools.

In discussion, the following points were made:

- It was important to get across to the public the message that social distancing measures might well be series of peaks and troughs, and not simply 'switched

off'. This might make the public clearer about the progression and less likely to flout restrictions. The cycle would not be broken definitively without a vaccine;
- further modelling would take place on all four causes of mortality in the paper to provide projections of possible numbers of deaths under different scenarios. Modelling to date suggested that indirect deaths (from emergency services becoming overwhelmed) were relatively low to date as the NHS was currently coping, but there did appear to be a small impact through patients' changed behaviour (e.g. late presentation of sepsis had been mentioned);
- Any introduction of COVID-19 into the UK from those returning from developing countries would be comparatively small compared to existing circulation within the population;
- school attendance for vulnerable children (with a social worker or Education, Health and Care Plan) was low to date, and a matter of concern (modelling had been done on the basis that it was possible to have up to 20% of pupils in school with a very small impact on the spread of the virus).
- It would be important to take a UK-wide view of when to relax social distancing. as peaks were unlikely to be aligned across the four nations.

Summing up, THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said that further work was necessary on the impacts of all four causes of mortality that had been set out and that the Group would come back to this conversation.

The Group:
- took note.